TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGERY CENTER

Respondent Name
ACADIA INSURANCE CO

MFDR Tracking Number
M4-17-2322-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please find the enclosed claim that you denied payment for timely filing. Please find enclosed our billing history as well as our system notes showing communication with your reps and confirmation sheets from faxing this claim to you. We even received a letter requesting that we bill on a 1500 within the 95 day time frame."

Amount in Dispute: $2,846.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2016	Ambulatory Surgical Care Services CPT Code 26952	$1,867.00	$1,867.00
	Ambulatory Surgical Care Services CPT Code 11042	$114.69	$144.69
TOTAL		$2,011.69	$2,011.69

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.

2. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 29-The time limit for filing has expired.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Is the requestor entitled to reimbursement for code 26952?
3. Is the requestor entitled to reimbursement for code 11042?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired."

   Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   In support of the position, the requestor submitted a letter from Forte-Acadia Ins dated October 31, 2016 requesting the provider bill on the correct form. The division finds the requestor has supported that the claim was submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is recommended.

2. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

   28 Texas Administrative Code §134.402(f)(1)(A) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
   > (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent .

   According to Addendum AA, CPT code 26952 is a non-device intensive procedure.

   The Medicare ASC reimbursement rate for code 26952 CY 2016 is $813.76.

   The City wage index for Grapevine, Texas is 0.9847.

   To determine the geographically adjusted Medicare ASC reimbursement for code 26952, use the following formula:

- The Medicare ASC reimbursement rate of $813.76 is divided by 2 = $406.88.
- This number multiplied by the City Wage Index $406.88 X 0.9847 = $400.65.
- Add these two together = $807.53.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$807.53 X 235% = $1,897.69. The respondent paid $0.00. The difference is $1,897.69. The requestor is seeking a lesser amount of $1,867.00; therefore, this amount is recommended.

3. The Medicare ASC reimbursement rate for code 11042 CY 2016 is $126.13.

Using the above formula, the division finds the MAR is $294.10. Code 11042 is subject to multiple procedure discounting; therefore, $1,188.06 X 50% = $147.05. The respondent paid $0.00. The requestor is seeking a lesser amount of $144.69. As a result, additional reimbursement of $144.69 is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,011.69.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,011.69 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		4/26/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.